STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	01		
		HAL043026	B. WING 03/0		9/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALZHEIN	MER'S RELATED CAR	E 217 JONE DUNN, NO	ESBORO RO C 28334	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Strickland on 03/09 Information from the that this facility was two twelve-bed facing twelve bed addition which joined the thirthirty-six beds under information, we are the 1996 Rules for Homes, the applicant Regulations for Adult Edition of the North Code-Institutional Code	e DHSR Database indicates is licensed on 02/02/1988 as lities. However, in 2003 a new was added on to the facility ree facilities for a total of er one license. Based on this requiring tha this facility meet the Licensing of Adult Care the portions of the 2005 alt Care Homes, and the 2002 a Carolina State Building Occupancy I-2.				
C 164	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of (e) This Rule shall facilities. This Rule is not me 1-Based on observe maintained and ser return air grilles.	es shall: ings, and floors or floor an and in good repair; c unpleasant odors; clean and in good repair; apply to new and existing et as evidenced by: ation, the facility has not viced the HVAC supply and	C 164			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

DIVISION	of Health Service Re	guiation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OI CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL043026	B. WING		03/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AI ZUEIN	IER'S RELATED CAR	E 217 JONE	SBORO RO	AD		
ALZHEIIV	IER 3 KELATED CAR	DUNN, NO	28334			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 164	Continued From pa	ge 1	C 164			
	build-up in all of the facility Residents Bathrooms.					
	2-Based on observation, the facility has not maintained the interior wall, ceiling and floor finishes in a safe mannter. Findings on 03/09/2015: The following locations have wall construction and floor finish issues: (a) There is a 10" x 16" sheet-rock cutout under the sink in the Salon Bathroom. (b) The floor finish in Room B10 and Laundry Room have not been cleaned and/or waxed recently. Old wax build-up occurs around where the floor intersects the walls and door frame. (c) All the ceiling diffusers in the corridors are rusted and have peeling paint. (d) The ceiling light trim ring is not covering the light fixture opening in the ceiling.					
	3-Based on observa maintained plumbin	ation, the facility has not g fixtures.				
		2015: e and leaking in the Salon dent Room B10 Bathroom.				
	4-Based on observa	ations, this facility has not door surfaces.				
	(a) Room A11 entry (b) Entry door for th Hall drags.	need maintainence:				

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Division of Health Service Regulation STATE FORM

STXX21 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		HAL043026	B. WING		03/0	03/09/2016		
				DRESS, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
C 189	Continued From page 2		C 189					
C 189	Building Equipment Maintained Safe, Operating		C 189					
	mechanical, and plucare home shall be operating condition (k) This Rule shall facilities with the exwhich shall not app This Rule is not meating the shal	d all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: ations, the facility emergency been maintained in a safe d affect all residents, staff and not providing illumination in the he event of an emergency.						
	does not provide illu	umination when test in the						
	emergency mode.							
C 199	Exhaust Ventilation		C 199					
	provided with exhautwo cubic feet per n requirement does n	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This ot apply to facilities licensed with natural ventilation in ces:						

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		HAL043026	B. WING		03/0	9/2016	
	NAME OF PROVIDER OR SUPPLIER ALZHEIMER'S RELATED CARE STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD DUNN, NC 28334						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
C 199	(3) bathrooms and (4) housekeeping of (5) laundry area. (k) This Rule shall facilities with the ex which shall not app. This Rule is not medial-Based on Observ provide an environmal Rule by not providing generated. This couby subjecting them.	toilet rooms; closets; and apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: ration, the facility failed to ment in accordance with this no ventilation where odors are all affect residents and staff to house-keeping odors.	C 199				

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Division of Health Service Regulation STATE FORM